Michigan Department of Community Health

CSHCS REQUEST TO ADD AND/OR TERMINATE OTHER INSURANCE

INSTRUCTIONS:

- PRINT or TYPE.
- Retain a COPY in LHD Case File.
- Attach clear copy of insurance card **(front and back)** when adding insurance.

Mail to:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
THIRD PARTY LIABILITY DIVISION
BUREAU OF FINANCIAL MANAGEMENT
PO BOX 30479
LANSING MI 48909

FAX

(517) 346-9817

E-Mail

TPL_Health@Michigan.Gov

SECTION 1 – Local Health Department Information

LHD Staff Person/Title	Date	County
Local Health Department	Parent/Guardian	
Local Health Department Phone Number ( )	Case Number (if available)	

SECTION 2 – List of Clients to Add Insurance

Client Name	Client ID Number	Date of Birth	Client Name	Client ID Number	Date of Birth
Client Name	Client ID Number	Date of Birth	Client Name	Client ID Number	Date of Birth

SECTION 3 – Add Health Insurance (including Medicare)

Policyholder Name	Social Security Number	Date of Birth
Commercial Insurance Name		
Member Number	Contract Number	Group/Policy Number

SECTION 4 – Add Additional Insurance

Pharmacy Insurance	Dental Insurance	Vision Insurance

SECTION 5 – Policyholder Employer Information

Employer Name
Employer Address (City and State)

SECTION 6 – List of Clients to Terminate Insurance

Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name
Client Name	Client ID Number	Date of Birth	Commercial Insurance Name

AUTHORITY: Title V of the Social Security Act

Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.